Summary of Regional Consultation Forums

- Comments both supporting and opposing the IHCIF formula were heard.
- There are a variety of views about the 60% threshold. Some proposed raising the threshold to 80% or 100% to include additional tribes in the distribution of funds. Others proposed lowering it to 40% to further concentrate funds for the most needy. Still others proposed a tiered or graduated approach. The Congress directed that funds go to the "most under funded units." The tradeoff is between concentrating funds to those most in need (a lower threshold) versus including a wider range of units (a higher threshold).
- The LNF methodology explicitly excludes infrastructure and "wrap-around" services. Both personal health services and "wrap-around" community health programs are important for raising health status of Indian people. IHS is proposing a new work group to develop a companion methodology for wrap-around programs. Many say that equity is not fully addressed until a companion wrap-around methodology is completed.
- Many suggest modifying the health status factor to focus on disease burden and disparities among Indian people and refining the IHCIF formula so that health status contributes more to results. After all, improving health status is the goal of IHS.
- Many oppose the global deduction of $745 for other health care resources as required in statute. Several concerns are raised. First, because health care is a federal responsibility based on treaties, counting other resources appears to roll back federal responsibility to tribes. Second, a single global amount will not reflect variations that may exist among local operating units. And, a number of tribal leaders link this issue with means testing principles which they oppose.
- Concerns regarding data consistency and quality were raised:
  - Active User Counts (gaps in data, unduplication of active users, and inclusion of users residing outside traditional service area boundaries)
  - Regional/local price variations (typical rural cost factors may understate true costs in remote areas)
  - Health Status Data (county level data is preferred if available and feasible)
- There were comments about the struggles to identify a fair cost index for Alaska. The vast size and distances, extreme remoteness, and a unique delivery system that has evolved there are cited. Most of Alaska is outside typical health care markets and cost/price data comparable to that from the lower 48 states is rarely available.
- Options were proposed to incorporate all or parts of the actuarial methodology to help formulate IHS budget requests.
- Identification of operating units based on the local delivery system was proposed as compared to service unit designations which may not reflect actual local practices.
- Fairness issues in counting Contract Support Costs were identified. Most support excluding all or part of CSC to maintain internal equity between direct service programs and self-determination programs.
- There was support to allocate the $40 million IHCIF at the earliest possible time. Most cite severe under funding and the needs for these funds. Others say it is important to distribute funds to the field before spring appropriations hearings.
- There are a variety of views about whether the $40 million IHCIF distribution in FY 2001 should be recurring or non-recurring.